General Assembly

Amendment

January Session, 2017

LCO No. **6588**

Offered by:
SEN. LOONEY, 11th Dist.
SEN. FASANO, 34th Dist.

To: Subst. Senate Bill No. **426** File No. 337 Cal. No. 184

"AN ACT CONCERNING CONTRACTS BETWEEN HEALTH CARRIERS AND HEALTH CARE PROVIDERS, AGENTS OR VENDORS, PARTICIPATING PROVIDER DIRECTORIES AND SURPRISE BILLS."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. Section 38a-477f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) **[**On and after January 1, 2016, no**]** No contract entered into or renewed between a health care provider, or any agent or vendor of a health care provider, and a health carrier shall contain a provision prohibiting disclosure of (1) billed or allowed amounts, reimbursement rates or out-of-pocket costs, **[**and**]** or (2) any data to the all-payer claims database program established under section 38a-1091. **[**for the purpose of assisting**]** Information described in subdivisions (1) and (2) of this subsection may be used to assist consumers and institutional

purchasers in making informed decisions regarding their health care and informed choices among health care providers and allow comparisons between prices paid by various health carriers to health care providers.

(b) If a contract described in subsection (a) of this section contains a provision prohibited under said subsection, the provision shall (1) be void and unenforceable, and (2) constitute an unfair method of competition and unfair or deceptive practice prohibited by sections 38a-815 to 38a-819, inclusive. The invalidity or unenforceability of any contract provision under subdivision (1) of this subsection shall not affect any other provision of the contract.

Sec. 2. Section 38a-477h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) As used in this section: (1) "Covered person", "facility" and "health carrier" have the same meanings as provided in section 38a-591a, (2) "health care provider" has the same meaning as provided in subsection (a) of section 38a-477aa, as amended by this act, and (3) "intermediary", "network", "network plan" and "participating provider" have the same meanings as provided in subsection (a) of section 38a-472f.

(b) (1) Each health carrier shall post on its Internet web site a current and accurate participating provider directory, updated at least **[**monthly**]** weekly, for each of its network plans. The health carrier shall ensure that **[**consumers are able to**]** any person may view, without any restrictions or limitations, all of the current participating providers for a network plan through a clearly identifiable link or tab on such health carrier's Internet web site. **[**, without being required to create or access an account or enter a policy or contract number.**]** The directory shall be accessible without any requirement that the individual seeking to access the directory (A) demonstrate coverage under the underlying network plan, (B) indicate interest in obtaining coverage under such plan, (C) create or access an account, (D) enter a

policy or contract number, or (E) provide any other personally identifiable information.

(2) Each health carrier shall provide, upon request from a prospective covered person, a covered person, or a covered person's representative, a print copy of such directory or of requested information from such directory. Such print copy shall be provided to the requester by mail postmarked not later than five business days following the date the request is received by the health carrier and may be limited to the geographic area where the requester resides or works or intends to reside or work. Each health carrier shall update the printed participating provider directory for each of its network plans at least quarterly.

(3) Each contract between a health carrier and a provider participating in a network plan shall require that the participating provider inform the health carrier not later than five business days after the date on which (A) the provider stops accepting new patients enrolled in the plan, or (B) the provider begins accepting new patients enrolled in the plan. Such contract shall provide the participating provider with information and instructions on how to make such notification through the online interface required under subsections (f) and (g) of this section.

(c) (1) A health carrier shall include in each such electronic or print directory the following information in plain language: (A) A description of the criteria the health carrier used to build its network; (B) if applicable, a description of the criteria the health carrier used to tier its participating providers; (C) if applicable, a description of how the health carrier designates the different participating provider tiers or levels in the network and identifies, for each specific participating provider, in which tier each is placed, such as by name, symbols or grouping, to allow a consumer to be able to identify the participating provider tiers; and (D) if applicable, a statement that authorization or referral may be required to access some participating providers.

(2) Each such directory shall also include a customer service electronic mail address, **[**and**]** telephone number **[**or**]** and an Internet web site address that covered persons or consumers may use to **[**notify**]** report to the health carrier **[**of**]** any inaccurate participating provider information in such directory. The health carrier shall promptly investigate any such report by, among other things, contacting the affected health care provider not later than five business days after submission of the report. The health carrier shall (A) take corrective action, if necessary, not later than thirty days after submission of the report to ensure that the affected provider directory is accurate, (B) notify the affected provider of the outcome of the investigation and the corrective action taken, if any, and (C) maintain a record of the investigation, outcome and corrective action, if any.

(3) Each health carrier shall make it clear for each such electronic or print directory which directory applies to which network plan, such as by including the specific name of the network plan as marketed and issued in this state.

(4) Each such electronic or print directory shall accommodate the communication needs of individuals with disabilities and include an Internet web site address or information regarding available assistance for individuals with limited English proficiency.

(d) (1) The health carrier shall make available through an electronic participating provider directory, for each of its network plans, the following information in a searchable format:

(A) For health care providers, (i) the health care provider's name, gender, participating office location or locations, specialty, if applicable, medical group affiliations, if any, facility affiliations, if applicable, participating facility affiliations, if applicable, (ii) any languages other than English spoken by such health care provider, and (iii) whether such health care provider is accepting new patients;

(B) For hospitals, the hospital name, the hospital type, such as acute, rehabilitation, children's or cancer, the participating hospital location

and the hospital's accreditation status; and

(C) For facilities other than hospitals, by type, the facility name, the facility type, the types of health care services performed at the facility and the participating facility location or locations and telephone number or numbers.

(2) In addition to the information required under subdivision (1) of this subsection, the health carrier shall make available through the electronic directory specified under subdivision (1) of this subsection, for each of its network plans, the following information:

(A) For health care providers, the health care provider's contact information, board certification and any languages other than English spoken by clinical staff, if applicable;

(B) For hospitals, the hospital's telephone number; and

(C) For facilities other than hospitals, the facility's telephone number.

(3) (A) Each health carrier shall make available in print, upon request, the following participating provider directory information for the applicable network plan:

(i) For health care providers, (I) the health care provider's name, contact information, specialty, if applicable and participating office location or locations, (II) any languages other than English spoken by such health care provider, and (III) whether such health care provider is accepting new patients;

(ii) For hospitals, the hospital name, the hospital type, such as acute, rehabilitation, children's or cancer and the participating hospital location and telephone number; and

(iii) For facilities other than hospitals, by type, the facility name, the facility type, the types of health care services performed at the facility and the participating facility location or locations and telephone

number or numbers.

(B) Each health carrier shall include with the print directory information under subparagraph (A) of this subdivision and in the print participating provider directory under subdivision (2) of subsection (a) of this section a statement that the information provided or included is accurate as of the date of printing, that covered persons or prospective covered persons should consult the health carrier's electronic participating provider directory on such health carrier's Internet web site and that covered persons may call the telephone number on such covered person's insurance card for more information.

(4) For the information required to be included in a participating provider directory pursuant to subdivisions (1) and (2) of this subsection, each health carrier shall make available through such directory the sources of such information and any limitations on such information, if applicable.

(e) Each health carrier shall, **[**periodically**]** at least annually, audit **[**at least**]** a reasonable sample size of its participating provider directories for accuracy and retain and provide documentation of such audit **[**to be made available**]** to the commissioner **[**upon request**]** not later than thirty days after completing such audit.

(f) Each health carrier shall take appropriate steps to ensure that the information contained in its provider directories is accurate and shall, at least annually, conduct a comprehensive review of the directory for each of its network plans. Each health carrier, as part of such comprehensive review, shall update and send written notice to each participating provider concerning (1) the processes the health carrier uses to notify each participating provider of the information contained in the directory, (2) the information contained in the directory concerning the provider, (3) instructions concerning the process by which each such provider can update or correct such information using an online interface, and (4) a list of all network plans that include the provider as a participating provider.

(g) Each health carrier shall implement processes to allow providers to promptly verify and submit changes to the information in provider directories. Such processes shall, at a minimum, include an online interface for providers to electronically submit verification of changes and shall generate an acknowledgment of receipt of such verification from the health carrier.

Sec. 3. Section 38a-477aa of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) As used in this section:

(1) "Emergency condition" has the same meaning as "emergency medical condition", as provided in section 38a-591a;

(2) "Emergency services" means, with respect to an emergency condition, (A) a medical screening examination as required under Section 1867 of the Social Security Act, as amended from time to time, that is within the capability of a hospital emergency department, including ancillary services routinely available to such department to evaluate such condition, and (B) such further medical examinations and treatment required under said Section 1867 to stabilize such individual, that are within the capability of the hospital staff and facilities;

(3) "Health care plan" means an individual or a group health insurance policy or health benefit plan that provides coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469;

(4) "Health care provider" means an individual licensed to provide health care services under chapters 370 to 373, inclusive, chapters 375 to 383b, inclusive, and chapters 384a to 384c, inclusive;

(5) "Health carrier" means an insurance company, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that delivers, issues for delivery, renews,

amends or continues a health care plan in this state;

(6) (A) "Surprise bill" means a bill for health care services, other than emergency services, received by an insured for services rendered by an out-of-network health care provider, where such services were rendered by such out-of-network provider (i) at an in-network facility, (ii) during a service or procedure performed by an in-network provider, **[**or**]** (iii) during a service or procedure previously approved or authorized by the health carrier, **[**and the insured did not knowingly elect to obtain such services from such out-of-network provider**]** or (iv) upon the referral of an in-network provider to an out-of-network provider.

(B) "Surprise bill" does not include a bill for health care services received by an insured when (i) an in-network health care provider was available or made available to the insured to render such services, and (ii) the insured knowingly **[**elected**]** and voluntarily consented, in writing, to obtain such services from **[**another**]** an out-of-network health care provider **[**who was out-of-network**]** and acknowledged, in writing, that such services might result in costs not covered by the health care plan. For scheduled health care services, the out-of-network health care provider shall obtain such written consent on the earlier of the date on which the health care provider, or any person on behalf of such provider, scheduled a date for the provider to render such services to the insured or the date on which the health care provider first discovered that the provider was an out-of-network provider, but in no event later than forty-eight hours before the health care provider rendered such services to the insured. For unscheduled health care services, the out-of-network health care provider shall obtain such written consent prior to rendering such services to the insured.

(b) (1) No health carrier shall require prior authorization for rendering emergency services to an insured.

(2) No health carrier shall impose, for emergency services rendered

to an insured by an out-of-network health care provider, a coinsurance, copayment, deductible or other out-of-pocket expense that is greater than the coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed if such emergency services were rendered by an in-network health care provider.

(3) No out-of-network health care provider shall request payment from an insured for emergency services, other than a coinsurance, copayment, deductible or other out-of-pocket expense authorized pursuant to subdivision (2) of this subsection.

[(3)**]** (4) (A) If emergency services were rendered to an insured by an out-of-network health care provider, such health care provider may bill the health carrier directly and the health carrier shall, not later than thirty days after receiving a complete bill from the out-of-network health care provider, reimburse such health care provider the greatest of the following amounts: (i) The amount the insured's health care plan would pay for such services if rendered by an in-network health care provider; (ii) the usual, customary and reasonable rate for such services; or (iii) the amount Medicare would reimburse for such services. As used in this subparagraph, "usual, customary and reasonable rate" means the eightieth percentile of all charges for the particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported in a benchmarking database maintained by a nonprofit organization specified by the Insurance Commissioner. Such organization shall not be affiliated with any health carrier.

(B) Nothing in this subdivision shall (i) be construed to prohibit such health carrier and out-of-network health care provider from agreeing to a greater reimbursement amount, or (ii) constitute a waiver of any right of either party, including any right to dispute the reimbursement provided pursuant to this subdivision.

(c) With respect to a surprise bill:

(1) **[**An insured shall only be required to pay the applicable

coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed for such health care services if such services were rendered by an in-network health care provider; and**]** No health carrier shall impose a coinsurance, copayment, deductible or other out-of-pocket expense that is greater than the coinsurance, copayment, deductible or other out-of-pocket expense the health carrier would have imposed if such services were rendered by an in-network health care provider;

(2) No out-of-network health care provider shall request payment from an insured other than a coinsurance, copayment, deductible or other out-of-pocket expense authorized pursuant to this subsection;

[(2) A**]** (3) (A) An out-of-network provider may bill the health carrier directly for the services rendered to the insured. The health carrier shall, not later than thirty days after receiving a complete bill from the out-of-network health care provider for such services, reimburse the out-of-network health care provider **[**or insured, as applicable,**]** for the health care services rendered **[**at the in-network rate under the insured's health care plan as payment in full, unless such health carrier and health care provider agree otherwise.**]** in an amount that is not less than the greater of (i) the average in-network rate under the insured's health care plan paid to similarly qualified health care providers for the same services in the same region, or (ii) the median in-network rate under the insured's health care plan paid to similarly qualified health care providers for the same services in the same region. The payment to the out-of-network provider shall include a notice certifying compliance with this section and citing the applicable average and median rates.

(B) Nothing in this subdivision shall (i) be construed to prohibit a health carrier or out-of-network health care provider from agreeing to a different reimbursement amount, or (ii) constitute a waiver of any right of either party, including any right to dispute the reimbursement provided pursuant to this subdivision.

(d) If health care services were rendered to an insured by an out-of-network health care provider and the health carrier failed to inform such insured, if such insured was required to be informed, of the network status of such health care provider pursuant to subdivision (3) of subsection (d) of section 38a-591b, the health carrier shall not impose a coinsurance, copayment, deductible or other out-of-pocket expense that is greater than the coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed if such services were rendered by an in-network health care provider.

Sec. 4. Subsection (a) of section 19a-904b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) Not later than **[**thirty**]** five business days after the date that a health care provider stops accepting patients who are enrolled in an insurance plan, such health care provider shall notify, in writing, the applicable health carrier."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2017*	38a-477f
Sec. 2	*October 1, 2017*	38a-477h
Sec. 3	*October 1, 2017*	38a-477aa
Sec. 4	*October 1, 2017*	19a-904b(a)